HARVARD UNIVERSITY
SCHOOL OF MEDICINE AND PUBLIC HEALTH
LIBRARY

8 DEC 1934

INTERNATIONAL CLINICS

Supplement December, 1934

Clinical Case Studies 7-8

FROM THE RECORDS OF THE
PITTSBURGH DIAGNOSTIC CLINIC
3509 FIFTH AVE. PITTSBURGH

PRINTED IN THE UNITED STATES OF AMERICA

FOREWORD

The object of these studies is to afford practice in the formulation of a diagnosis on the basis of the history and physical findings, together with such technical procedures, X-ray studies, and opinions of specialists as may seem to be indicated. Actual case records are used, unchanged except for the deletion of identifying names and such editing as may seem advisable for the sake of brevity and clearness.

DIRECTIONS

Proceed on the basis that each case is a patient under your own care. The general history and physical findings as printed in this supplement represent what you would learn from the first visit of the patient in your office. After studying these make up your mind as to the most likely working diagnosis and put this in writing in the space provided for "Notes", this being solely for your own reconsideration in light of later information. Select the enclosed post card correspondingly numbered with the case problem you are studying and check off on the card the special procedures which you feel are definitely indicated; do not ask for everything blindly but for only such studies as you would order if this were your own private patient. Mail the card promptly to the Pittsburgh Diagnostic Clinic, making certain to show your name and address.

You will receive from the Clinic two packets for each case. In one, will be the information you requested, provided it is available. Study this material and make up your mind as to the final diagnosis, putting your opinion in writing on the page provided for "Notes". Then open the second packet which contains the final report made by the Clinic Staff, and follow-up information as to the patient's subsequent clinical course which serves as a check on the accuracy of the diagnosis.

It is particularly urged that you commit yourself in writing at every stage of the study because a comparison of the provisional with the final diagnosis will frequently prove most instructive.

GENERAL HISTORY

White Female Married Age 57 years

CHIEF COMPLAINT

Nervousness, loss of weight, feeling of lump in the upper abdomen and loss of appetite.

PRESENT ILLNESS

The patient has never recovered from the debilitating effects of rather severe menopause which began at the age of 49, eight years ago, and continued for two years, during which each menstrual period was characterized by marked flooding. Six years ago this stopped entirely. During those two years there was not any great amount of nervousness, but there was considerable weakness and anemia incident to the excessive loss of blood. Since then to the present time she has not been particularly well, but the particular symptoms that constitute her present complaint have been markedly exaggerated during the past two years, these being first and foremost a constant feeling of weight and fullness in the midepigastrium, a marked loss of appetite, and a steady loss of weight, and finally, a sense of general nervousness, characterized chiefly by a tendency to worry and insomnia. The loss of weight has been quite marked. Eight years ago, before the beginning of her symptoms, she weighed well over 200 pounds, being quite fat and having a hearty appetite and perfect digestion. Two years ago her weight had dropped to 174, this remained about stationary for a year, then dropped to 160, and eight weeks ago it was 152, at the present time it is 137½, indicating a loss of 15 pounds in the last two months. Despite this increase in the loss of weight in the past few months, she believes that she is eating about as much as usual. Aside from the above symptoms she states that there are no others. She does not have any headache or trouble with the eyes, ears, or throat;

no symptoms referable to the heart or lungs; no history of any pains in the stomach, or nausea or vomiting. Bowels are regular, moving on an average of two or three times each morning, not showing any change in color or any blood. When she forces herself to eat there is no pain or indigestion. The heavy, full sensation in the midepigastrium is apparently quite independent of the taking of food; no urinary disturbances.

PAST HISTORY

Past history is essentially negative up until the onset of the present illness. She has always been inclined to be obese, but very active and energetic and perfectly well in every respect; no history of any acute illness; no chronic illness; no trouble with the eyes, ears, nose, throat, heart, lungs, gastro-intestinal or genito-urinary tracts.

Marital history—married twice; first husband died several years ago of nephritis, but she was divorced from her first husband when her only child was four years of age, this being almost 30 years ago. Married again about two years later, this second husband is living and well, but the patient has never been pregnant by the second husband. Menopause six to eight years ago as described under present illness.

Habits—regular as to eating and sleeping. Able to carry on a certain amount of routine duties but very restless, nervous and worried since present illness.

PHYSICAL EXAMINATION

GENERAL

Height 64½ inches Weight 137½ pounds Temperature 98.8°

Patient is normally developed, but shows evidence of marked loss of weight, she appears very introspective and neurotic. There is a slight but definite brownish pigmentation to the skin of the entire body, a little accentuated over points of pressure; this pigmentation, however, is hardly sufficient to be typical of any particular illness; no cyanosis, no signs of jaundice.

HEAD AND NECK

Ears—negative. Eyes—pupils are equal, react normally, associated movements normal except for a moderately positive von Graefe. Mouth—remaining teeth are fairly well preserved, moderate pyorrhea. Throat—only slightly injected, tonsils are deep and several plugged crypts are visible. Glands—no general enlargement; thyroid—not enlarged.

THORAX

Percussion note somewhat less resonant over the right upper front and back, and over this area the breath sounds are intensified, almost tubular, no moisture is heard. Aside from the change in the right upper, the lungs are otherwise clear throughout.

Heart—normal size, rate is 84, regular in force and rhythm; sounds are all clear, no murmurs. Pulse—84, regular, no abnormal thickening of vessel wall.

ABDOMEN

Abdominal walls are flabby, respiratory movements are normal. Patient complains of slight tenderness on palpation in the

right upper abdomen and to a lesser extent in the midline, but there is no muscle resistance. On palpation in the right upper, one feels a rounded, somewhat irregular, nodular, fairly firm mass descending under the hand, probably a moderately enlarged, firm gall bladder, although it might be a kidney. The spleen is not felt. Palpation over the abdomen is otherwise negative except that the coils of the intestine feel rather firm, but no hard indurated masses or enlargements can be made out. No abnormal peristalsis.

EXTREMITIES

No edema; reflexes are all normal; no tremor.

BLOOD PRESSURE

Systolic, 150.
Diastolic, 80.

NOTES

MY PROVISIONAL DIAGNOSIS

Based on History and General Physical Examination.

MY REVISED DIAGNOSIS

Taking into consideration reports on Special Studies.

GENERAL HISTORY

White Male Married Age 58 years

CHIEF COMPLAINT

Loss in weight and strength.

PRESENT ILLNESS

Patient has not felt well for the past two years; prior to that time he considered his general health good. He first began to tire more easily than formerly and noticed that he contracted colds readily and that they persisted for long periods of time. The loss in strength continued so that it was only with a good deal of effort that he carried on his work. He would go to bed early at night to get plenty of rest but by the end of a working day, he was almost entirely exhausted. The loss in weight did not begin until eight months ago. Prior to this he had weighed 195 pounds and maintained his weight at a constant level. He then began to lose and during the past three months he has lost 36 pounds and has become increasingly nervous. At the present time he has no particular symptoms other than his nervousness and loss in weight and strength. He still contracts colds rather easily and at times has a troublesome cough, usually of the dry type. His appetite is good; as a rule he has no digestive disturbances; he does not vomit, become nauseated, and has not had any acute pain. About a week ago, however, he developed a generalized soreness over the abdomen, more noticeable in the upper abdomen in the gastric region extending over to the right side beneath the costal border. While there was no acute pain with this, his abdomen was apparently quite sore and it took him several days before the soreness was relieved. His bowels have been chronically constipated; it has been necessary for him to resort to cathartics for some time; during the past ten days he

has taken castor oil daily. Kidneys apparently function normally, getting up about twice a night to void. He has noticed recently some dyspnea upon exercise, but attributes this to the fact that he is generally weak. His left lower leg swells a good deal because of varicose veins; he wears an elastic stocking on the left leg which makes him quite comfortable; there has not been any edema of the right leg. Ordinarily, he sleeps well.

PAST MEDICAL HISTORY

Patient had diphtheria in childhood; in 1912 he had typhoid fever; he has not had any operations.

Family history—entirely negative.

Personal history—patient is 58 years of age, married, four children; his occupation is that of a meat cutter; he chews more than a moderate amount of tobacco; takes an occasional drink of alcoholic beverage. About 32 years ago he had a Neisserian infection which cleared up and has given him no symptoms since. Two years ago all his teeth were removed.

PHYSICAL EXAMINATION

GENERAL

Height 72 inches Weight 160¾ pounds Temperature 98.4°

Patient is a normally developed, well nourished adult male, appearing to be his given age; he presents a rather marked pallor and appears somewhat anemic, but there is no abnormal pigmentation. There is no evidence of cyanosis or jaundice; mental attitude, gait, and speech are normal.

HEAD AND NECK

Eyes—pupils are equal, react to light and accommodate to distance; ears and nose—negative. Mouth—all teeth have been removed. His tongue is uniformly red, having the appearance of a mild inflammatory condition; he states that at times it is sore and there are times when he has some soreness in the roof of his mouth. Pharynx is negative; tonsils do not appear diseased. Neck—thyroid is definitely enlarged, particularly the left lobe which is quite prominent, easily palpable, and hard. There are no cervical glands palpable.

THORAX

Chest is normal shape; well nourished; respirations are regular and even; lungs are clear throughout.

Heart—the apex beat can be palpated in the fifth intercostal space, about the midclavicular line; action is fairly strong and regular; rate is 74 per minute; there are no murmurs or thrills present.

ABDOMEN

Abdomen is normal shape; there is some tenderness on deep pressure in the epigastric region, extending over to the right side

beneath the right costal border. No mass can be felt; there is no particular muscle rigidity. The liver is not enlarged; spleen and kidneys cannot be palpated.

EXTREMITIES

There are some varicose veins in the left lower leg with some edema of this extremity. Reflexes—knee jerks are subnormal but equal. There is fairly marked, persistent fine tremor of the fingers. Pulse—fairly strong and regular, rate is 74 per minute. Skin is negative.

BLOOD PRESSURE

Systolic, 120.
Diastolic, 78.

NOTES

MY PROVISIONAL DIAGNOSIS

Based on History and General Physical Examination only.

MY REVISED DIAGNOSIS

Taking into consideration the reports requested on Special Studies.